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Health History Questionnaire for Genetics Testing

Name of Client being tested: ______________________________ Date: ____/_______/______

Ethnicity: ____________________ Date of Birth: ____/_______/______

If Deceased, Date of Death: ____/_______/______

Cause of Death: ____

Name of person filling out form and relationship to client: _____________________________

What question would you like answered by genetics testing?
____
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MEDICAL CONDITIONS OF CLIENT AND CLIENT'S BIOLOGICAL FAMILY				
Condition	**Client**	**Mother's Family** list relationship e.g., parent, grandparent, aunt, uncle, sibling	**Father's Family** list relationship e.g., parent, grandparent, aunt, uncle, sibling	**Comments**
Respiratory				
Allergies				
Asthma				
Bronchitis				
Emphysema				
Tuberculosis				
Cystic Fibrosis				

Gastrointestinal	CLIENT	Mother's Family	Father's Family	Comments
Ulcers				
Inflammatory Bowel				
other				

Cardiovascular	CLIENT	Mother's Family	Father' s Family	Comments
High Blood Pressure				
Heart Attack				

Stroke				
Cardiomyopathy				
Congestive Heart Failure				
Atherosclerosis				
Heart Rhythm Abnormality				
Congenital Heart Defect				

Immune/ Hematological	**CLIENT**	**Mother's Family**	**Father's Family**	**Comments**
Mononucleosis				
Hemophilia				
Leukemia				
Lymphomas				
Hodgkin's Disease				
Other Cancer				

Renal	**CLIENT**	**Mother's Family**	**Father's Family**	**Comments**
Kidney Failure/Dialysis/ Transplant				
Other Kidney Problems				

Liver Disease	**CLIENT**	**Mother's Family**	**Father's Family**	**Comments**
Hepatitis (specify type)				
Cirrhosis				
Other Liver Disease				

Central Nervous System	**CLIENT**	**Mother's Family**	**Father's Family**	**Comments**
Dementia (list type)				
ALS (Lou Gehrigs's Disease).				
Epilepsy				
Hydrocephalus				
Multiple Sclerosis				
Huntington's Chorea				
Seizures/Convulsions				

Endocrine	CLIENT	Mother's Family	Father's Family	Comments
Diabetes (Adult or Juvenile)				
Thyroid (hyper/hypo)				
Adrenal				

Muscular/ Skeletal	CLIENT	Mother's Family	Father's Family	Comments
Club Foot				
Scoliosis (Curvature of the Spine)				
Arthritis (Osteo or Rheumatoid)				
Cleft lip or Palate				
Lupus				

Neuromuscular	CLIENT	Mother's Family	Father's Family	Comments
Cerebral Palsy				
Muscular Dystrophy				
Spina Bifida				

Visual/Auditory	CLIENT	Mother's Family	Father's Family	Comments
Blindness				
Glaucoma				
Cataracts or other eye problems				
Deafness or other hearing problems				

OTHER MEDICAL CONDITIONS OF CLIENT AND CLIENT'S BIOLOGICAL FAMILY				
Mental Illness (list type, e.g., Depression, Bipolar, Schizophrenia				
Alcohol or Drug Abuse				
Eating Disorders				
Mental Retardation				
Give age at death & cause of death of CLIENT's grand-parents, aunt, uncle, and siblings:				
Other				

BIRTH PARENT'S FAMILY HISTORY

Were you or any family member of your immediate family adopted? Yes ☐ No ☐
If yes, please tell which family member:

	BIRTH MOTHER	BIRTH FATHER
Date of Birth (or approximate age of DOB if unknown)		
If deceased, age at and cause of death.		
Approximate Height & Weight		
Eye Color/Skin Tone		
Hair Color & Texture		
Build (e.g., petite, large boned)		

Race BIRTH MOTHER	Race BIRTH FATHER
☐ Asian ☐ American Indian or Alaskan Native If American Indian or Alaskan Native, specify name of tribe and degree of Indian blood (if known): ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unable to Determine Multi-Racial (specify):	☐ Asian ☐ American Indian or Alaskan Native If American Indian or Alaskan Native, specify name of tribe and degree of Indian blood (if known): ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unable to Determine Multi-Racial (specify):
Ethnicity BIRTH MOTHER	**Ethnicity BIRTH FATHER**
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unable to Determine Nationality:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unable to Determine Nationality:

Other Information: